Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

Carrier's Austin Representative Box

15

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Date Received

JUNE 8, 2006

MFDR Tracking Number

M4-06-6516-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated June 7, 2006: "Pursuant to Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's usual and customary charges, which is $97,270.75."

Requestor's Supplemental Position Summary Dated December 12, 2011: "Enclosed please find the Curriculum Vitae and Affidavit of Patricia L. Metzger, Chief of Care Management for Memorial Hermann."

Affidavit of Patricia L. Metzger dated November 21, 2011: "I am the Chief of Care Management for Memorial Hermann Healthcare System (the 'Hospital')." "Based upon my review of the records, my education, training, and experience in patient care management, I can state that based upon the patient's diagnosis and extent of injury, the services and surgical procedures performed on this patient were complicated and unusually extensive."

Amount in Dispute: $71,115.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated November 18, 2011: "Requestor asserts that, as a trauma admission, reimbursement should be based upon the hospital's usual and customary charges. This is fundamentally incorrect. 'Usual and customary,' may be a billing standard. It is never a reimbursement standard. Instead, where the primary diagnosis is listed as an exempt ICD 9 trauma code, reimbursement should be analyzed under a fair and reasonable standard. *Id*. Per Respondent's Explanation of Benefits, the admission was reimbursed at 85% of the audited billed charges. Carrier's payment of $26,155.45 is fair and reasonable for the services provided. No additional reimbursement is due."

Response Submitted by: Downs Stanford, P.C., 115 Wild Basin Road, Suite 207, Austin, TX 78746

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
June 7, 2005 through June 21, 2005	Inpatient Hospital Services	$71,115.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

97-Charge included in another Charge or Service.
131-Claim specific negotiated discount.
W1-Workers compensation state fee schedule adjustment.
42-Charges exceed our fee schedule or maximum allowable amount.
150-Payment adjusted because the payer deems the information submitted does not support this level of service.
50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Findings

1. According to the explanation of benefits, the respondent reduced the reimbursement based upon reason code "131-Claim specific negotiated discount". The "PPO Discount" amount on the submitted explanation of benefits denotes a $2,906.16 discount was taken. The respondent did not submit documentation to support that a contractual agreement exists and that the PPO discount taken was appropriate; therefore, reimbursement for the disputed services will be reviewed in accordance with applicable division rules and guidelines.
2. According to the explanation of benefits, the respondent denied reimbursement of $657.18 of the $4,277.25 charges for revenue code 270 based upon "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer." The explanation of benefits further explains that "Based upon a review of billed charges this appears to be an overcharge and/or excessive amount for services rendered." The explanation of benefits does not list or identify which medical or surgical supplies were denied based upon reason code "50". The respondent did not maintain this denial reason in the position summary. Furthermore, the respondent issued payment of $26,155.75 for the hospitalization. The Division finds that the basis of this dispute is a fee dispute applicable to 28 Texas Administrative Code §133.307.
3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the

entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 805.4. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor seeks full reimbursement of the billed charges based upon "Pursuant to Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's usual and customary charges, which is $97,270.75."
   - The requestor does not discuss or explain how additional payment of $71,115.00 would result in a fair and reasonable reimbursement.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		11/14/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		11/14/2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.